MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (X) Yes ( ) No
Requestor's Name and Address **Houston Premier DME** **4141 North Freeway, Ste. 206** **Houston, TX 77022**	MDR Tracking No.: M4-04-4675-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 19 Metropolitan Transit Authority	Date of Injury: Employer's Name: Metropolitan Transit Authority Insurance Carrier's No.: 0300860

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
06/18/03	06/18/03	E0236	365.20	365.20
Total Amount Due				$365.20

PART III: REQUESTOR'S POSITION SUMMARY

The insurance carrier "CONSCIOUSLY" refuses to pay the MAR for the unit that TWCC has stated in the 1991 TWCC MFG. We strongly disagree with the reason given by the insurance carrier because TWCC does indeed have a MAR of $490.20 for this item.

PART IV: RESPONDENT'S POSITION SUMMARY

Paid for cryotherapy unit at fair and reasonable per MBMS database. Pad, set-up training and fitting are included in the cost of the purchase price. In this case, the 1991 MFG D0368 code or price does not apply.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The original EOB denial reason of medical necessity was resolved upon reconsideration and partial payment by the Respondent. The Respondent's assertion that the 1991 MFG D0368 does not apply is incorrect. The TWCC's 1996 MFG Durable Medical Equipment Ground Rule IX. Billing, C. directs carriers to pay fair and reasonable reimbursement, which is the same as the rates set for the "D" codes in the 1991 MFG. Section §413.016(c) states the carrier shall be directed to submit the difference to the provider if they reduced a charge that was within the guidelines.

The descriptor for the Code D0368 – Pump for water-circulating pad - is the same as E0236 the disputed item billed. As such the proper reimbursement for this item is $490.20. The Respondent's reimbursement is not fair and reasonable and the Requestor is entitled to $365.20, the difference for the disputed item.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of **$365.20** . The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Patti Lanfranco Typed Name	June 29, 2005 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
P. O. Box 17787
Austin, Texas, 78744
or faxed to (512) 804-4011

A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____